

Woods, Amanda L., Miller, Paul K. and Sloane, Charles (2015) Patient obesity and the practical experience of the medical imaging professional: an interpretative phenomenological analysis. In: UK Radiological Congress (UKRC), 29 June - 1 July 2015, ACC Liverpool, UK.

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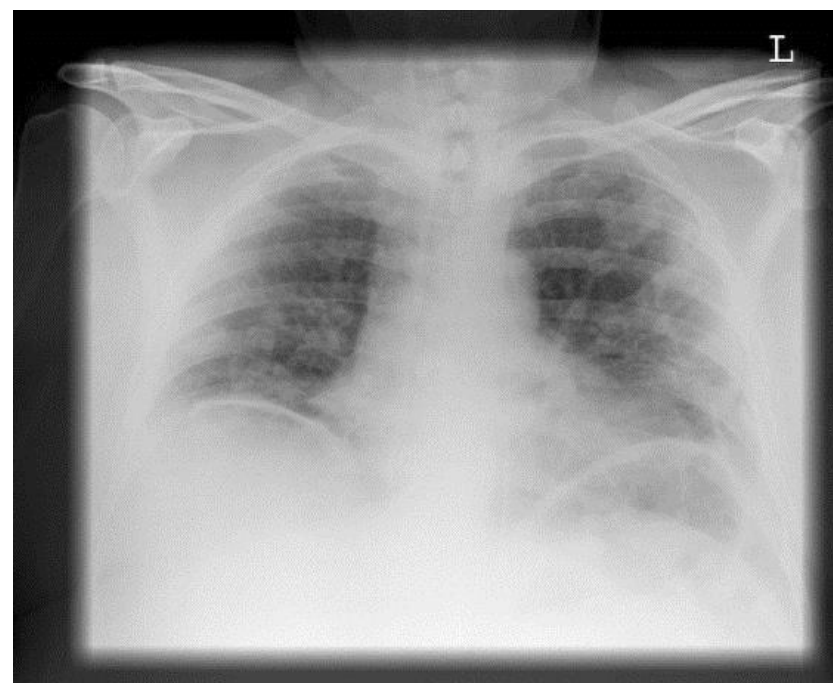
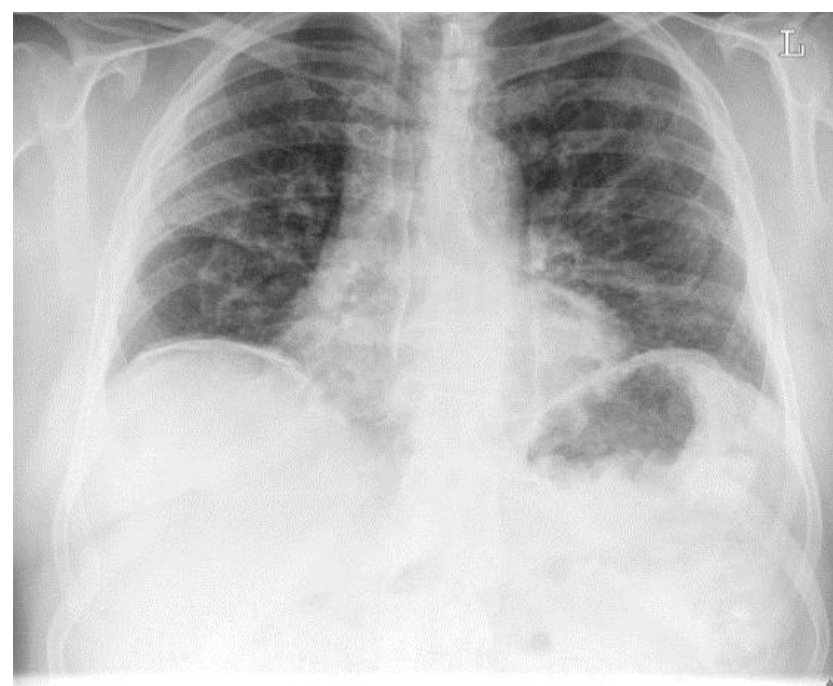

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Patient obesity and the practical experience of the medical imaging professional: An interpretative phenomenological analysis

Amanda Woods*, Paul K. Miller & Charles Sloane

Background	<p>The rising tide of obesity in the West affects all socioeconomic groups, ages and genders (WHO, 2014). Coronary heart disease, diabetes mellitus, osteoarthritis and respiratory problems are, moreover, all (a) worsened by obesity, and (b) contributors to workload in radiology departments (Shah et al, 2011). While there is ample evidence regarding the function of medical imaging in helping obese (<i>bariatric</i>) patients (Lee, McAlexander and Banda, 2011), however, there remains limited formal research into the practical ways in which patient obesity impacts upon the nuanced everyday practice of professional radiographers.</p>	 	
Method	<p>Interpretative Phenomenological Analysis (IPA) was used to explore the everyday practical issues faced by medical imaging professionals when handling the cases of bariatric patients. Employing a sample of N=8 such professionals, with 5-35 years of front-line experience, open-ended, semi structured interviews were conducted (mean duration = 30 minutes). The questioning itself progressed from descriptive to analytical and evaluative. Data were analysed in line with the standard idiographic techniques of IPA (Smith, Flowers & Larkin, 2009). Analysis revealed four superordinate themes, outlined below.</p>	<p>AP chest of obese patient taken on a trolley (top), and same patient using grid in erect Bucky (bottom).</p>	
Results and Discussion	<h3>I. “Unsuitable” Kit</h3> <p>“[S]ometimes we are unable to use the hydraulics on the table.”</p> <p>“Sometimes fitting them on the image receptor can be difficult, so when we’ve got someone for a chest, we may end up actually doing two exposures.”</p>	<h3>II. Diagnostics</h3> <p>“Image quality is decreased due to scatter in large patients...you are unable to exclude a fracture because image quality is so bad and so much quantum mottle...”</p> <p>“[W]ith a chest you have to use a grid straight off, if you see an obese patient.”</p>	
	<h3>III. Practical Motion</h3> <p>“[S]ometimes they struggle to move into the position that we need, sometimes you’ve got to compromise...”</p> <p>“I think probably one of the biggest problems we’ve had...is actually sitting the patient forwards and placing the receptor behind them.”</p>	<h3>IV. Communicative Stigma</h3> <p>“[I]t was a bit embarrassing at the time, probably for her as well. [H]ow do you bring up some of these things, you know?”</p> <p>“Actually we’re embarrassed, I was embarrassed to bring the subject up.”</p>	
	Conclusion	<p>Radiology departments need to effectively prepare for imaging bariatric patients in order to reduce the number of repeated projections, missed diagnosis and embarrassing situations for the professional and patient alike (see also Buckley et al., 2009). However, given the still-rising rates of obesity in the UK and elsewhere in the West, it may be necessary to incorporate some aspects of bariatric medicine into core education in medical imaging – not least that relating to practical communication and the handling of awkward topics in real-world contexts.</p>	
	Refs	<p>Buckley, O., Ward, E., Ryan, A., Colin, W., Snow, A. & Torreggiani, W. C. (2009). ‘European Obesity and the Radiology Department. What Can We Do To Help?’ <i>European Society of Radiology</i>. 19, pp.298-309.</p> <p>Lee, R. E., McAlexander, K. & Banda, J. (2011) <i>Reversing the obesogenic environment</i>. Leeds: Human Kinetics.</p> <p>Shah, S., Shah, V., Ahmed, A. R. & Blunt, D. M. (2011) ‘Imaging in bariatric surgery: service set-up, post-operative anatomy and complications’, <i>The British Journal of Radiology</i>, 84 (998), pp.101-111.</p> <p>Smith, J. A., Larkin, M. & Flowers, P. (2009) <i>Interpretative Phenomenological Analysis: Theory, Method and Research</i>. London: Sage.</p>	